

S. No. 2
-12-45
5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15964
Registrar's No. 858

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St. Louis "Rural"
(b) City or town Rural
(c) Name of hospital or institution: Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 185 days
In this community 185 days
years, months or days (Specify whether)

3. (a) PRINT FULL NAME LUCAS, SCOTT
3. (b) If veteran, name war No
3. (c) Social Security No. 489-05-3976

4. Sex Male 5. Color Negro
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Adabelle Lucas
6. (c) Age of husband or wife if alive 9 years
7. Birth date of deceased 1 9 05
(Month) (Day) (Year)

8. AGE: Years 42 Months 2 Days 25
If less than one day hr. min.

9. Birthplace MONROE, LA.
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business

MOTHER FATHER

12. Name JULIUS LUCAS
13. Birthplace LA.
14. Maiden name Rowena A Lucas
15. Birthplace LA.

16. (a) Informant Hosp Records
(b) Address Koch Hospital

17. (a) Burial (b) Date thereof 4 11 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oakdale Cemetery

18. (a) Signature of funeral director A. S. Burk
(b) Address 212 E. 12th St

19. (a) 4-12-47 (b) Carol A. G. Shapiro
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1532 S 32nd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 4
year 47 hour 9 minute 04 A M.

21. I hereby certify that I attended the deceased from 10-1-46 to 4-4-47
and that death occurred on the date and hour stated above.
that I last saw h. im alive on 4-4-47
and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC PULMONARY TUBERCULOSIS
Duration about 6 months

Due to mk
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury
Signature Bernard Friedman M. D. or other M.D.
Address Koch Hosp Koch, Mo. Date signed 4-4-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate, was embalmed by me, or by _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Licensed Embalmer No. *42437*

P. O. Address. *137 E. 1st St.
Cincinnati, Ohio*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.